Women and Birth 29 (2016) 18–23

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Midwives' experiences of transfer in labour from a Western Australian birth centre to a tertiary maternity hospital

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ARTICLE INFO

Article history:
Received 12 April 2015
Received in revised form 7 July 2015
Accepted 9 July 2015

Keywords:
Midwife
Intrapartum
Transfer
Continuity
Birth centre

ABSTRACT

Background: When transfer in labour takes place from a woman-centred, midwifery led centre to a tertiary maternity hospital it is accepted that women are negatively affected, however the midwife's role is unevaluated, there is no published literature exploring their experience. This study aimed to describe these experiences.

Methods: Giorgi's descriptive phenomenological method of analysis was used to explore the 'lived' experiences of the midwives. Seventeen interviews of transferring midwives took place and data saturation was achieved.

Findings: The overall findings suggest that midwives find transfer in labour challenging, both emotionally and practically. Five main themes emerged: (1) 'The midwife's internal conversation' with subtheme: 'Feeling under pressure', (2) 'Challenged to find a role in changing circumstances' with subtheme: 'Varying degrees of support', (3) 'Feeling out of place' with subtheme: 'Caught in the middle of different models of care, (4) 'A constant support for the parents across the labour and birth process' with subthemes: 'Acknowledging the parents' loss of their desired birth' and (5) 'The midwives' need for debrief'.

Conclusion: Midwives acknowledged the challenge of finding the balance between fulfilling parents' birth plan wishes with hospital protocol and maintaining safety. Transfer for fetal or maternal compromise caused anxiety and concern. The benefits of providing continuity of care were acknowledged by the midwife's knowledge of the woman and her history but these were not always recognised by the receiving team. Discussing the transfer story afterwards helped midwives review their practice. Effective communication between all stakeholders is essential throughout the transfer process.

1. Introduction

Maternity care options have been under review over the last decade in Australia. The Reid Report[1] and The Report of the Maternity Services Review[2] identified the need for improved choice and information about maternity care for pregnant women as a priority with a recommendation to increase access to birth centres (BC) and models offering continuity of care. The benefits of woman-centred care for low-risk women who birth at home or in BC are well established internationally, with women opting for these models experiencing more spontaneous vaginal births, fewer medical interventions and greater satisfaction.[3–5] Equally beneficial, the value of continuity of care models have been demonstrated to increase the feeling of being in control for women and to also provide greater overall satisfaction[6] as well as reduced levels of regional analgesia, episiotomy and instrumental birth.[7] Furthermore, these models have been found to increase satisfaction for midwives[8,9] in addition to reducing health care costs.[10]

Midwives choosing to offer continuity of care in Western Australia (WA) have the option of working independently or in a group practice or team, either privately or under the umbrella of the Department of Health. One such model is a birth centre (BC), in WA, where low-risk women can labour and birth in a home-like environment. In WA in 2011, of the 31,734 women that gave birth, 1.2% were booked for midwife-led BC care.[11]

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http://dx.doi.org/10.1016/j.wombi.2015.07.007
1871-5192/

In a BC setting it is expected that the majority of women will have a normal vaginal birth. However, a UK based study suggests that approximately 25% of women may be transferred to a referral hospital during labour[12] and a New Zealand study[13] found the rate to be 17%. In this BC in WA between July 2013 and June 2014, the rate was in between. Of the 609 women booked to birth in the BC, 259 (43%) were transferred during the antenatal period to the tertiary obstetric unit (TOU). Of the remaining 350 women, 118 (19%) were transferred in labour leaving 232 (38% of the total bookings) birthing in the birth centre.[14]

Evidence suggests that intrapartum transfer may cause negative emotions for the woman and her partner who often face anxiety and disappointment amongst other emotions.[15,16] However, the third party involved, the midwife's role is unevaluated; currently there is no published literature exploring their experience during such a transfer from a BC to a TOU. Although women and partner's experiences of intrapartum transfer have been explored, the midwife's experience in this scenario is missing.

Although generally not all midwives are women, in this BC all midwives are female and so are referred to as she/her.

Continuity of care models vary,[7] but in the case of the BC context in this study, the midwife meets the woman at 15–20 weeks of pregnancy, takes her antenatal history and is central to helping her plan for the birth. When transfer takes place in labour, the midwife who transfers with her from the BC to the hospital, is often in the difficult position of being aware of the importance of the woman's birth plan but now has to take action that is outside of the woman's preferences. This conflict and the whole process of transfer has the propensity to be traumatic for the midwife due to the need to make the decision in a timely fashion, advise the parents calmly but realistically, inform the receiving personnel, and arrange transportation. No research has been undertaken to highlight the reality of the BC transfer experience for the midwife.

2. Literature review

Although there are no Australian or international studies exploring the BC to hospital transfer from the midwife's perspective, there are two recent international studies exploring midwives' experiences of intrapartum transfer from home to hospital. A qualitative English study, using phenomenological methodology, discovered five main themes.[17] The ten midwives who were interviewed revealed difficulties surrounding the decision to transfer; the importance of supporting the parents; the significance of collaborative working; the ongoing organisational challenges and the need for a reliable ambulance service. Their findings suggest that the midwife relies on confidence and expertise when making the decision to transfer and that this decision making may cause her fear and anxiety. The midwives suggested a need for openness and honesty to build relationships with parents in order to foster trust, respect and confidence. The need for collaboration with health professionals was stressed, with a focus on communication, teamwork and support. The limitations of this study include the small number of midwives interviewed, as acknowledged by the authors. Another omission in the paper is the interval of time between the transfer and interview of the midwife. The length of time could influence the midwife's recollection of events.

A qualitative American study, researching the transfer experience from home to hospital in labour or immediate postpartum period interviewed and observed 24 transferring midwives and 16 receiving obstetricians.[18] The American study authors acknowledged that obstetricians were more difficult to recruit which could have distorted results whereby being discontented was the cause of coming forward. The three main themes that emerged from the receiving staff related to the perceived danger of home birth, the concern of having to 'pick up the pieces' and the poor documentation and communication leading to costly delays. The first of three midwives' themes was the perceived lack of holistic care by receiving staff, the second focused on the bias of physicians and the third theme was midwives wanting physicians to have insight into the poor national obstetric outcomes rather than focusing on the small number of homebirth transfers. The findings from this study highlighted the need for mutual respect and communication between the homebirth midwives and the receiving hospital staff.

The findings from these two international studies provide insight into the challenges midwives face during transfer from home to hospital but neither is wholly related to an Australian setting. They do demonstrate how the challenges vary between international healthcare contexts. The difference between contexts reinforces the gap in knowledge and the need for a study to explore the experiences of Australian midwives when transfer from a BC to a TOU occurs. Insight into midwives experiences will inform midwifery knowledge as well as facilitate collaboration between health professions.

3. Subjects and methods

A qualitative design was chosen due to its characteristic flexibility and holistic approach which strives for understanding of the whole experience[19] and the subjective description from participants' words to gain rich data and insight into human experiences.[20,21] To capture the lived experience of intrapartum transfer from midwives' perspectives, a descriptive phenomenological study design was chosen as it is based on recognition that "participants have lived through an experience from which relevant opinions, values or beliefs have emerged" (p. 106).[21] In this study, the phenomenon was *the intrapartum transfer*, as described from the midwife's perspective. In order to elicit personal perceptions and descriptions of the experience, in-depth interviews were conducted.[19]

The study setting was a midwife-led birth centre in WA, which is in a separate building but adjacent to the TOU. The BC provides a home-like environment in order to enable women to feel more at ease so that stress hormones are reduced and the chance of normal progress of labour is enhanced.[22,23] In this BC women were allocated to a small group of 5 midwives who provided on-call midwifery care across the continuum of antenatal, intrapartum and postnatal care. The aim of this model of team midwifery was that the women would meet all 5 midwives in the group during the antenatal period in order to increase the probability of being cared for by a known midwife in labour. This enabled the development of a relationship between the woman and midwives in order to build trust and respect for birth and the postnatal period. During antenatal appointments and in childbirth education classes, couples were educated about the choices they can make and were encouraged to carry out their own research to support information already provided to facilitate their desired pregnancy and birth experience. The reasons for and rates of transfer were also discussed in the antenatal period and a tour of the tertiary labour ward offered to prospective parents in order to reduce anxiety and increase familiarity in case transfer in labour was to take place.

The inclusion criteria for study participants were midwives who cared for women in the BC who were transferred to the TOU intrapartum and then stayed with the woman and her partner for the remainder of her labour and birth or until her shift ended. Ethical approval was obtained from the University's Human Research Ethics Committee (HR91/2013) and the Hospital Human Ethics committee (2013031EW).